

**TRANSMITTAL AND NOTICE OF APPROVAL
OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER
00-6

2. STATE
Illinois

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)**

4. PROPOSED EFFECTIVE DATE:

June 1, 2000

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 431.11 & Section 1902(a)(4) Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 - \$670,254.00

b. FFY 2001 -\$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, page 8 and page 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (if Applicable):

Attachment 4.19-B, page 8 and page 9

10. SUBJECT OF AMENDMENT: **METHODS AND STANDARDS FOR ESTABLISHING ~~INPATIENT~~ ^{OUTPATIENT} RATES FOR HOSPITAL
REIMBURSEMENT**

11. ☐ GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☒ OTHER, AS SPECIFIED:

Not submitted for review by prior
approval.

12. SIGNATURE OF AGENCY OFFICIAL: *Ann Patla*

13. TYPED NAME: Ann Patla

14. TITLE: DIRECTOR

15. DATE SUBMITTED:

6-28-00

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62762
ATTENTION: Lynn Handy
Deputy DIRECTOR

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

1/29/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

12/1/00

20. SIGNATURE OF REGIONAL OFFICIAL: *Cheryl A. Harris*

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE
OF CARE BASIS FOR REIMBURSEMENT

- 06/00 E A one-time State fiscal year 2000 payment will be made to qualifying hospitals. Payment will be based upon the services, specified below, provided on or after July 1, 1998, and before July 1, 1999, which were submitted to the IDPA and determined eligible for payment (adjudicated) by the Department on or prior to April 30, 2000 excluding services for Medicare/Medicaid crossover claims and claims which resulted in no payment by the Department.
- (i) A payment of \$27.75 for each service for procedure code W7183.
- (ii) A payment of \$24.00 for each service for APL Group 5.a. (Psychiatric clinic Type A) services provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A) and Attachment 4.19A, Chapter 11.C.3 in the Illinois Medicaid State Plan.
- (iii) A payment of \$15.00 for each service for APL Group 6.b (Physical rehabilitation clinic) services provided by a children's hospital as defined in 89 Ill. Adm. Code 149.50(c)(3)(A) and Attachment 4.19A, Chapter 11.C.3 in the Illinois State Plan.
- 07/99 GE.F. For county-owned hospitals located in an Illinois county with a population greater than three million, reimbursement rates for each of the reimbursement groups shall be equal to the amount described in subsection D. above, multiplied by a factor of two. However, such rates shall be no lower than the rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
- 07/99 BFG. The rate for each group is all-inclusive for services provided by the hospital. Reimbursement for each APL group described in subsection b.i. shall be all-inclusive for all services provided by the hospital, regardless of the amount charged by a hospital. No separate reimbursement will be made for ancillary services or the services of hospital personnel. ~~The one exception is~~ Exceptions to this provision are that hospitals shall be allowed to bill separately, on a fee-for-service basis, for professional outpatient services of a physician ~~physicians~~ providing direct patient care who ~~is~~ are salaried by the hospital, and occupational or speech therapy services provided in conjunction with rehabilitation services as described in subsection b.i. of this Section ~~who~~

TN # 00-6
Supersedes
TN # 99-04

APPROVAL DATE _____

EFFECTIVE DATE 06-01-00

State Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE BASIS FOR REIMBURSEMENT

~~provide emergency Level I or II services in the emergency department.~~ For the purposes of this Section, a salaried physician is a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide emergency department care. Under APL reimbursement, salaried physicians do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists and no separate reimbursement will be allowed for such providers.

07/99

F.G.H. The Department of Public Aid will reimburse ambulatory surgical treatment centers (ASTCs) for facility services in accordance with covered APL groups as defined in this section. The Department may exclude from coverage in an ASTC any procedure identified as only appropriate for coverage in a hospital setting. All groups that may be reimbursed to an ASCT are defined in the Department's hospital handbook and notices to providers. Reimbursement levels shall be the lower of the ASTC's usual and customary charge to the public or an all inclusive rate for facility services, which shall be 75 percent of the applicable APL rate.

1. Facility services furnished by an ASTC in connection with covered APL codes include, but are not limited to:
 - a. Nursing, technician and related services;
 - b. Use of the ASTC facilities;
 - c. Supplies (such as drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of surgical procedures;
 - d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
 - e. Administrative, record keeping, and housekeeping items and services; and
 - f. Materials for anesthesia.
2. Facility services do not include items and services for which payment may be made under other provisions of this Section such as physicians' services, laboratory, x-ray or diagnostic procedures performed by independent facilities or practitioners on the day of surgery (other than those directly related to performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home. In addition, they do not include anesthetist services.
- iii. The assignment of procedure codes to each of the reimbursement groups in subsection b.i. of this Section are detailed in the Department's Hospital Handbook and in notices to providers.

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TN # 99-04

APPROVAL DATE _____ EFFECTIVE DATE 06-01-00